DEPARTMENT OF HEALTH

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth in an Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption, on an emergency basis, of an amendment to section 929 of Chapter 9 of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR), entitled "Supported Employment Services." These rules establish standards governing reimbursement by the District of Columbia Medicaid Program for Supported Employment Services, a habilitative service provided to participants with mental retardation and developmental disabilities in the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver), which was approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, with an effective date of November 20, 2007.

A notice of emergency and proposed rulemaking was published on December 21, 2007 (54 DCR 12353). Comments were received and considered. The December 21st rulemaking changed the previously published rules at 51 DCR 4095 (April 23, 2004), to increase the options for supported employment by adding micro-enterprises and group activity, to establish more specific and formal outcomes for the different service components, and to add rates for professionals, paraprofessionals, and group supports. This rulemaking further changes the December 21st rulemaking to provide new standards for supported employment professional or supervisory positions, to remove the requirement for college degrees in a social services area only, to modify the Job Coach and Employment Specialist credentials to be consistent with the new supervisory position, to modify the minimum employment standards and the process for requesting extended services, to modify reporting requirements to reflect the need to regularly update the individual supports plan on how the person is participating in respect to wage and employment standards established in the rule, to modify group supported employment to establish a maximum number of people who can be supported at a single site and to remove the requirement that each person be employed at least twenty (20) hours per week to maintain eligibility.

Emergency action is necessary for the immediate preservation of the health, safety, and welfare of Waiver participants who are in need of supported employment services. These emergency rules are needed so that, on the expiration date of the previous notice of emergency and proposed rulemaking for supported employment services, there will be rules in place consistent with the provisions of the Waiver.

The emergency rulemaking was adopted on March 13, 2008, and will become effective on March 19, 2008. The emergency rules will remain in effect for 120 days or until July 11, 2008, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*, whichever comes first.

The Director also gives notice of the intent to take final rulemaking action to adopt these proposed rules not less than thirty (30) days from the date of publication of this notice in the *D.C. Register.*

Section 929 (Supported Employment Services) of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

929 SUPPORTED EMPLOYMENT SERVICES

929.1 Supported employment services shall be reimbursed by the District of Columbia Medicaid Program for each participant in the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver) subject to the requirements set forth in this section.

929.2 Supported employment is intended for individuals for whom competitive employment has not traditionally occurred or has been interrupted. The aim of supported employment services is to emphasize the assets, preferences and skills of the person and to match the person to a job that maximizes those assets and minimizes deficits.

929.3 Supported employment shall consist of paid competitive work that offers ongoing support services in an integrated work setting where wages are paid at or above minimum, consistent with the Fair Labor Standards Act. The level of employment participation may be full-time or part-time based on the interests and abilities of the individual.

929.4 Supported employment services eligible for reimbursement shall be as follows:

(a) Intake and assessment;
(b) Job placement;
(c) Job training and support; and
(d) Follow-along services.

929.5 Supported employment services are ineligible for reimbursement if the services are available to the person through programs funded under Title I of the Rehabilitation Act of 1973 (Pub. L. 93-112; 29 U.S.C. § 720 *et seq.)* or the Individuals with Disabilities Education Act (Pub. L. 91-230; 20 U.S.C. § 1400 *et seq.)* (hereinafter the "Acts"). Each person receiving supported employment services shall submit documentation that demonstrates that services are not otherwise available pursuant to the Acts referenced above, for inclusion in his or her record and individual habilitation plan (IHP) or individual support plan (ISP) and Plan of Care. Court-ordered vocational assessment shall be provided by authorizing intake and assessment services

under this section if services provided through programs funded under Title I of the Rehabilitation Act of 1973 cannot provide assessment services in the timeframe set forth in the Court's Order.

929.6 Professionals authorized to provide supported employment activities without supervision are as follows:

(a) Vocational Rehabilitation Counselor;
(b) A person with a Master's degree and a minimum of one (1) year of experience working with persons with intellectual and developmental disabilities;
(c) A person with a bachelors degree and two years of experience working in supported employment; or
(d) A Rehabilitation Specialist.

929.7 Paraprofessionals authorized to perform supported employment activities under the supervision of a professional listed in section 929.6 are as follows:

(a) Job Coaches; or
(b) Employment Specialists.

Supervision is not intended to mean that the paraprofessional performs supported employment activities in view of the professional authorized in section 929.6, but rather that the paraprofessional has a supervisor who meets those qualifications.

929.8 Intake and assessment activities include, but are not limited to, the following:

(a) Conducting an individualized vocational and situational assessment;
(b) Developing an individualized employment plan that includes the person's job preferences and desires;
(c) Assessing person-centered employment information, including the employee's interest in doing the job, transportation to and from work, family support, and financial issues;
(d) Counseling an interested person on the tasks necessary to start a business; and
(e) Providing individual and/or group employment counseling.

929.9 As a result of intake and assessment activities, the provider shall complete and deliver a comprehensive vocational assessment report to the Department on Disability Services (DDS) Service Coordinator that includes the following:

(a) Employment-related strengths and weaknesses (*e.g.*, task focus);
(b) Available family and community supports;
(c) Personal concerns;
(d) Accommodations and supports that may be required on the job; and

(e) If a specific job or entrepreneurial effort has been targeted the assessment may also include:
(1) Individualized training needed to acquire and maintain acceptable production skills;
(2) Anticipated level of interventions that will be required by the job coach;
(3) Type of integrated work environment in which the person can potentially succeed; and
(4) If the individual is not immediately employable, activities and supports that are need to improve potential for employment.

929.10 Intake and assessment activities shall be billed at the unit rate. This service shall not exceed three hundred twenty (320) units annually. A standard unit of service is fifteen (15) minutes and the provider shall provide at least eight (8) continuous minutes of service to bill one (1) unit of service. The reimbursement rate is forty-three dollars ($43.00) per hour if performed by a professional listed in section 929.6. The reimbursement rate is twenty-five dollars and thirty cents ($25.30) per hour if performed by a paraprofessional under the supervision of a professional listed in section 929.7. If extended intake and assessment services are required, the provider shall submit a written justification to the DDS Service Coordinator and the DDA Waiver Office a minimum of ten (10) business days before the prior authorized services have been expended. DDS shall review the submission and approve or disapprove the request for extension within ten (10) business days of receipt. Services shall continue if DDS does not respond to the written request within ten (10) business days of receipt. Disapproval will be accompanied by notice of Fair Hearing Rights through the Department of Health's Medical Assistance Administration (MAA). The disposition also shall be documented in the person's IHP or ISP and Plan of Care. Intake and assessment shall be prior authorized by DDS as a discrete service and no other supported employment services will be approved without the development and delivery of the completed vocational assessment to the DDS Service Coordinator.

929.11 Job placement activities eligible for reimbursement include, but are not limited to, the following:

(a) Conducting workshops or other activities designed to assist the person in completing employment applications or preparing for interviews;
(b) Conducting workshops or other activities to instruct persons on proper work attire, behaviors and expectations;
(c) Completing job applications with or on behalf of the person;
(d) Assisting the person with job exploration and placement, including assessing opportunities for advancement;
(e) Visiting employment sites and attending employment networking events;

(f) Making telephone calls to prospective employers, utilizing the internet, magazines, newspapers and other publications as leads;
(g) Collecting descriptive data regarding various types of employment opportunities, for purposes of preparing a standardized set of requirements for prospective employees;
(h) Negotiating employment terms with or on behalf of the person;
(i) Working with the person to develop and implement a plan to start a business, including developing a business plan, developing investors or start up capital, and other tasks necessary to starting a small business; and
(j) Working with interested persons and employers to develop group placements.

929.12 Job placement activities shall be billed at the unit rate. This service shall not exceed four hundred (400) units annually. A standard unit of service is fifteen (15) minutes and the provider shall provide at least eight (8) continuous minutes of service to bill for one (1) unit of service. The reimbursement rate is forty-three dollars ($43.00) per hour when performed by a professional listed in section 929.6. The reimbursement rate is twenty-five dollars and thirty cents ($25.30) per hour if performed by a paraprofessional under the supervision of a professional listed in section 929.7. If extended job placement services are required, the provider shall submit a written justification in support of the extended services to the DDS Service Coordinator and the DDA Waiver Office a minimum of ten (10) business days before the prior authorized services have been expended. DDS shall review the submission and approve or disapprove the request for extension within ten (10) business days of receipt. Services shall continue if DDS does not respond to the written request within ten (10) business days of receipt. Disapproval will be accompanied by notice of Fair Hearing Rights through MAA. The disposition shall be documented in the person's IHP or ISP and Plan of Care.

929.13 Job training and support activities are those activities designed to assist and support the person after employment has been obtained. The expectation is that the job training and support activities are faded as the individual gains job skills, and support from the existing work structure is increasingly sufficient to maintain employment. Job training and support activities eligible for reimbursement include, but are not limited to, the following:

(a) On-the-job training in work and work-related skills required to perform on the job;
(b) Work site support that is intervention-oriented and designed to enhance work performance, modify inappropriate behaviors, re-training as jobs change, ongoing counseling, and assistance to ensure job retention;
(c) Supervision and monitoring of the person in the workplace;

(d) Training in related skills essential to obtaining and maintaining employment, such as the effective use of community resources, break or lunch rooms, transportation systems, mobility training and changing jobs.
(e) Monitoring and providing information and assistance regarding wage and hour requirements, appropriateness of placement, integration, number of hours worked, need for adaptations and offsite supports such as transportation services;
(f) Consulting with other professionals and the person's family, as necessary; and
(g) Consulting with the person's employer, co-workers or supervisors, as necessary.

929.14 Job training and support activities shall not exceed one thousand, two hundred and eighty (1280) units per Plan of Care year. A standard unit of service is fifteen (15) minutes and the provider shall provide at least eight (8) continuous minutes of service to bill one (1) unit of service. The reimbursement rate is forty-three dollars ($43.00) per hour when performed by a professional listed in section 929.6. The reimbursement rate is twenty-five dollars and thirty cents ($25.30) per hour if performed by a paraprofessional under the supervision of a professional listed in section 929.7. If extended job training and support activities are required the provider shall submit a written justification in support of the extended services to the DDS Service Coordinator for review. DDS shall review the submission and approve or disapprove the request for extension within ten (10) business days of receipt. Services shall continue if DDS does not respond to the written request within ten (10) business days of receipt. Disapproval will be accompanied by notice of Fair Hearing Rights through MAA. The disposition also shall be documented in the person's IHP or ISP and Plan of Care.

929.15 Long-term follow-along activities eligible for reimbursement include, but are not limited to, the following:

(a) Periodic monitoring of job stability;
(b) Interventions to address issues that threaten job stability;
(c) Providing retraining or cross training when job duties change;
(d) Facilitating integration and natural supports at the job site; and
(e) Facilitating job advancement and job mobility.

929.16 Follow-along activities shall be reimbursed at the same rates as set forth in section 929.14 and shall not exceed seven hundred and sixty-eight (768) units per Plan of Care year. A standard unit of service is fifteen (15) minutes and the provider shall provide at least eight (8) continuous minutes of service to bill one (1) unit of service. If extended follow-along services are required, the provider shall submit a written justification to the DDS Service Coordinator and the DDA Waiver Office a minimum of ten (10) business days before the

prior authorized services have been expended. DDS shall review the submission and approve or disapprove the request for extension within ten (10) business days of receipt. Services shall continue if DDS does not respond to the written request with ten (10) business days of receipt. Disapproval will be accompanied by notice of Fair Hearing Rights through MAA. The disposition also shall be documented in the person's IHP or ISP and Plan of Care.

929.17 The three models of supported employment eligible for reimbursement shall be as follows:

(a) Individual job support;
(b) Group supported employment; and
(c) Entrepreneurial.

929.18 Group supported employment services are delivered when there is more than one (1) person at the job site who is receiving supported employment services from the supported employment services provider. The job coach shall provide training and other services as described in 929.13 to each Waiver participant as needed. The rate for this service is sixteen dollars and forty cents per hour ($16.40) billable in fifteen (15) minute units of four dollars and ten cents ($4.10). The provider shall provide at least eight (8) continuous minutes of service to bill one (1) unit of service. This rate assumes a maximum of four (4) persons are receiving support in the same job location, and are receiving job coaching services from one (1) supported employment services staff person. Each Waiver participant may be billed for the time the job coach is supporting any of the four (4) participants.

929.19 Each provider shall provide the ongoing supports at the work site needed for the person to obtain job stability after employment has been obtained. Once the person is stable on the job, the provider shall make a minimum of two (2) job site contacts per month for the purpose of monitoring job stability.

929.20 Reimbursement for supported employment services provided at the work site in which persons without disabilities are employed shall only be made for adaptations, supervision and training required by the person who receives Waiver services pursuant to these rules. No payment shall be made for supervisory activities, which are rendered as a normal part of the business setting.

929.21 When applicable, each provider shall be certified by the U.S. Department of Labor.

929.22 When applicable, each provider shall coordinate with DDS/DDA and the employer for the provision of appropriate services for each person requiring

physical assistance to accomplish basic activities of daily living on the work site.

929.23 When applicable, each provider shall coordinate with the employer to ensure that each person has access to appropriate first aid on the work site.

929.24 Supported employment services shall be pre-authorized and provided in accordance with each person's IHP or ISP and Plan of Care.

929.25 Each provider shall develop a plan that addresses how the provider will meet the needs and communicate with non-English speaking persons.

929.26 Each provider of supported employment services shall be a social services agency as described in Chapter 19 of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR), Section 1903.1. In addition, the provider agrees to:

(a) Be a member of the person's interdisciplinary team;
(b) Have a current District of Columbia Medicaid Provider Agreement that authorizes the provider to bill for Supported Employment Services under the Waiver; and
(c) Maintain a copy of the most recent IHP or ISP and Plan of Care that has been approved by DDS for each person.

929.27 Each person providing supported employment services for a provider under section 929.26 shall meet the requirements in Chapter 19 to Title 29 of the District of Columbia Municipal Regulations (DCMR), section 1911.

929.28 Supported employment services may be provided either exclusively as the vocational service or in combination with prevocational or day habilitation services. Supported employment services shall not be provided concurrently with day treatment, day habilitation or prevocational services.

929.29 Supported employment services shall be provided for a maximum of eight (8) hours in a day and five (5) days in a week. The provider shall submit a written justification in support of the extended services to the DDS Service Coordinator for review. DDS shall review the submission and approve or disapprove the request for extension within ten (10) business days of receipt. Any disapproval shall be accompanied by notice of Fair Hearing Rights through MAA. The disposition shall be documented in the person's IHP or ISP and Plan of Care.

929.30 Supported employment services providers shall not bill for incentive payments, subsidies or unrelated vocational training expenses such as the following:

(a) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment services program;
(b) Payments that are passed through to users of supported employment services programs; or
(c) Payments for vocational training that is not directly related to the person's supported employment services program.

929.31 Each supported employment services provider shall maintain service records that accurately and adequately link the services billed to the IHP or ISP and Plan of Care for each participant receiving services, including:

(a) Person's name;
(b) Staff person's name;
(c) Date(s) of activities;
(d) Start and end times of activities;
(e) Purpose of activities; and
(f) Location of activities.

929.32 Each supported employment services provider shall record and report:

(a) Occurrences or behaviors by a participant that impede the progress of the group or the individual participant;
(b) Any unusual circumstances or events that impact the stability of the group or the individual participant;
(c) Any individual unusual incidents; and
(d) Actions taken to address behaviors or unusual circumstances.

929.33 Supported employment services providers shall submit to the DDS Service Coordinator a completed quarterly update of the IHP or ISP. The report shall include:

(a) Name of the each person;
(b) Confirmation that wages exceed minimum wage;
(c) Average hours a week worked by each person;
(d) Hours of activities for each person if not engaged in employment; and
(e) Aggregate calculation of wages earned, hours worked and hours of activities for persons not engaged in employment.

929.34 Each supported employment services provider shall maintain a copy of each person's record at least six (6) years after the date of discharge.

929.35 Time spent in transportation to and from the program shall not be included in the total amount of services provided per day. However, time spent in transportation to and from the program for the purpose of training the participant on the use of transportation services may be included in the

number of hours of services provided per day for a period of time specified in the person's IHP or ISP and Plan of Care.

929.99 DEFINITIONS

When used in this section, the following terms and phrases shall have the meanings ascribed:

Employment Specialist – A person with a four-year college degree and a minimum of three (3) years of experience in a supported employment program; a person with a college degree and certification from the Commission on Rehabilitation Counselor Certification or a similar national organization; or a person with a high school degree and three (3) years of experience in a supported employment program.

Entrepreneurial – Development and on-going support for micro-enterprises owned and operated by the participant. This assistance consists of: (a) assisting the participant to identify potential business opportunities; (b) assisting the participant in the development of a business and launching a business; (c) identification of the supports that are necessary in order for the participant to operate the business; and (d) ongoing assistance, counseling and guidance once the business has been launched.

Group – An employment situation in competitive employment in which a group of four or fewer participants with disabilities are working at a particular work setting. The participants may be disbursed throughout the company and among workers without disabilities or congregated as a group in one part of the business.

Individual Habilitation Plan (IHP) – That plan as set forth in section 403 of the Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978, effective March 3, 1979 (D.C. Law 2-137; D.C. Official Code § 7-1304.03).

Individual Supported Employment – A supported employment strategy in which a job coach places a participant into competitive employment through a job discovery process, provides training and support, and then gradually reduces time and assistance at the work site.

Individual Support Plan (ISP) – The successor to the individual habilitation plan (IHP) as defined in the 2001 Plan for Compliance and Conclusion of *Evans v. Williams*.

Intake – A process designed to obtain information about the person and their needs as it relates to community integration and employment.

Integrated Work Setting – A work setting that provides daily contact with other employees and/or the general public.

Job Coach – A person with a four-year college degree and a minimum of one (1) year of experience in a supported employment program; a person with a college degree in a social services discipline and certification from the Commission on Rehabilitation Counselor Certification or a similar national organization; or a person with a high school degree and three (3) years of experience in a supported employment program.

Long-term follow along activities – Ongoing support services necessary to assure job retention.

Person or Participant – An individual with intellectual and developmental disabilities who has been determined eligible to receive services under the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver).

Plan of Care – A written service plan that meets the requirements set forth in section 1904.4 of Title 29 DCMR, is signed by the person receiving services, and is used to prior authorize Waiver services.

Provider – Any non-profit, home health agency, social service agency or other business entity that provides services pursuant to these rules.

Waiver – The Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities as approved by the Council of the District of Columbia (Council) and the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), as may be further amended and approved by the Council and CMS.

Rehabilitation Specialist – A persons with a Master's degree in Rehabilitation Counseling or a similar degree from an accredited university; a person with a Master's degree in a social services discipline and a minimum of one (1) year of experience in a supported employment program; or a person with a Master's degree in a social services discipline and certification from the Commission on Rehabilitation Counselor Certification or a similar national organization.

Situational Assessment – A type of assessment that provides the person an opportunity to explore job tasks in real work environments in the community. This assessment is useful in identifying the type of employment that may be beneficial to the person and the support required by each person to succeed in the work environment. Provides competitive or real work sites in the community for the systemic assessment and observation of the person; identifies work site characteristics and person adaptations, training procedures, support needs related to the person's success in supported employment; and recommends specific plans for further services, including the appropriateness of continuing supported employment.

Vocational Assessment – An assessment designed to assist persons, their family and service providers with specific employment related data that will generate positive employment outcomes. The assessment outlines the life, relationships, challenges, and perceptions of the person as they relate to potential sources of community support and mentorship.

Vocational Rehabilitation Counselor – A persons with a Master's degree in Vocational Counsel Counseling, Vocational Rehabilitation Counseling or a similar degree from an accredited university; a person with a Master's degree in a social services discipline and a minimum of one (1) year of experience in a supported employment program; or, a person with a Master's degree in a social services discipline and certification from the Commission on Rehabilitation Counselor Certification or a similar national organization.

Comments on the proposed rules shall be submitted in writing to Robert T. Maruca, Senior Deputy Director, Medical Assistance Administration, Department of Health, 825 North Capitol Street, N.E., 5th Floor, Washington, D.C. 20002, within thirty (30) days from the date of publication of this notice in the *D.C. Register*. Copies of the proposed rules may be obtained from the same address.

DEPARTMENT OF HEALTH

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption, on an emergency basis, of an amendment of section 934 (Physical Therapy Services) of Chapter 9 (Medicaid Program) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR). These rules establish standards governing reimbursement by the District of Columbia Medicaid Program for physical therapy services provided to participants with mental retardation and developmental disabilities in the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver), which was approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, with an effective date of November 20, 2007.

A notice of emergency and proposed rulemaking was published on December 14, 2007 (54 DCR 12068). No comments were received. The December 14th rulemaking changed the previously published rules at 53 DCR 97 (January 6, 2006), by providing for more effective planning and follow-up reporting. This rulemaking further changes the December 14th rulemaking by modifying the definition of private practice so that qualified social services agencies employing licensed physical therapists can provide physical therapy services.

Emergency action is necessary for the immediate preservation of the health, safety, and welfare of Waiver participants who are in need of physical therapy services. These emergency rules are needed so that, on the expiration date of the previous notice of emergency and proposed rulemaking for physical therapy services on March 18, 2008, there will be rules in place consistent with the provisions of the Waiver as modified to include more effective planning and follow-up reporting, and to permit qualified social services agencies employing licensed physical therapists to provide these Waiver services.

The emergency rulemaking was adopted on March 13, 2008, and became effective on March 18, 2008. The emergency rules shall remain in effect for 120 days or until July 10, 2008, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*, whichever comes first.

The Director also gives notice of the intent to take final rulemaking action to adopt these proposed rules not less than thirty (30) days from the date of publication of this notice in the *D.C. Register.*

Section 934 of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

934 PHYSICAL THERAPY SERVICES

934.1 Physical therapy services shall be reimbursed by the District of Columbia Medicaid Program for each participant with mental retardation and developmental disabilities in the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver) subject to the requirements set forth in this section.

934.2 To be eligible for reimbursement, physical therapy services shall be:

(a) Ordered by the person's physician;

(b) Reasonable and necessary to the treatment of the person's illness, injury, or long term disability, or to the restoration or maintenance of function affected by the injury, illness, or long term disability; and

(c) Included in the person's individual habilitation plan or individual support plan and Plan of Care.

934.3 Each individual providing physical therapy services shall be an employee of a home health agency or a physical therapist in private practice with a current District of Columbia Medicaid Provider Agreement that authorizes the provider to bill for physical therapy services under the Waiver.

934.4 In addition to the other requirements of this section, a physical therapist in private practice shall meet all of the following conditions:

(a) Maintain a private office, even if services are always furnished in the person's home;

(b) Meet all state and local licensure laws and rules;

(c) Maintain a minimum of one million dollars in professional liability insurance;

(d) If services are provided in a private practice office space, the space shall be owned, leased, or rented by the private practice and be used exclusively for the purpose of operating the private practice; and

(e) Physical therapy assistants and physical therapy aides shall be personally supervised by the physical therapist. Assistants and aids shall also be employed by the physical therapist or the partnership group to which the physical therapist belongs or the same private practice that employs the physical therapist. Personal supervision requires the physical therapist to be in the room during the performance of the service.

934.5 Each individual providing physical therapy services shall:

(a) Be a licensed physical therapist;

(b) Have a minimum of two (2) years of experience as a physical therapist;

(c) Be acceptable to the person to whom services are provided;

(d) Demonstrate annually that he or she is free from communicable disease as confirmed by an annual PPD Skin Test or documentation thereof from a physician;

(e) Have the ability to communicate with the person to whom services are provided;

(f) Be able to read, write, and speak the English language; and

(g) Comply with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238; D.C. Official Code § 44-551 *et seq.*).

934.6 Each physical therapist, at least annually, shall provide the Department on Disability Services (DSS) and the Department of Health, Medical Assistance Administration, with a brochure, in printed or electronic form, listing his or her academic background, licensure information, experience, and the nature of his or her practice to assist Waiver enrollees in making provider selection decisions.

934.7 Physical therapists, without regard to their employer of record, shall be selected by the person to receive services, or that person's guardian or legal representative**,** and shall be answerable to the person receiving services. Any organization substituting practitioners for more than a two (2) week period or four (4) visits due to emergency or availability events shall request a case conference with the DDS Case Manager so that the person receiving services may select a new practitioner.

934.8 The duties of each provider shall include, at a minimum, the following:

(a) Preparing a report that summarizes the physician's order, measures the person's strength, range of motion, balance and coordination, posture, muscle performance, respiration, and motor functions. Additionally, developing and describing treatment plans that provide treatment strategies, including direct therapy, training caregivers, monitoring

requirements, monitoring instruments, monitoring instructions, and anticipated outcomes;

(b) Maintaining ongoing involvement and consultation with other service providers and caretakers;

(c) Ensuring that the person's needs are met in accordance with the physician's order;

(d) Providing consultation and instruction to the person, family, or other caregivers;

(e) Recording progress notes on each visit; and

(f) Conducting periodic examinations and modifying treatments for the person receiving services, when necessary.

934.9 The physical therapist shall be responsible for providing written documentation in the form of reports, assessments for physical therapy services, physician's orders, progress notes, and other pertinent documentation of the person's progress or lack of progress, medical conditions, functional losses, and treatment goals that demonstrate that the services are and continue to be reasonable and necessary. The documentation shall include evidence that services did not exceed the authorized frequency and duration as authorized for physical therapy services in the physician's order. The home health agency or physical therapist in private practice shall maintain a copy of the documentation for at least six (6) years after concluding services to the person.

934.10 The reimbursement rate for physical therapy services shall be sixty-five dollars ($65.00) an hour for a full assessment of the individual, preparation of summary documentation, and delivery of that documentation. The billable unit of service for physical therapy services shall be fifteen (15) minutes. A provider shall provide at least eight (8) minutes of service in a span of fifteen (15) continuous minutes in order to bill a unit of service. Billable services shall include updating medical records and verifying that the summary documentation was delivered to the person, or his or her guardian or legal representative, to the physician, and to DDS.

934.11 The reimbursement rate for ongoing physical therapy services shall be sixty-five dollars ($65.00) per hour for the period specified in the physical therapy report and approved by the physician. The billable unit of service for physical therapy services shall be fifteen (15) minutes. A provider shall provide at least eight (8) minutes of service in a span of fifteen (15) continuous minutes in order to bill a unit of service.

934.12 For persons between the ages of 18 and 21 years, EPSDT under the District of Columbia State Plan for Medical Assistance shall be fully utilized before accessing physical therapy services under the Waiver.

934.99 DEFINITIONS

When used in this section, the following terms and phrases shall have the meanings ascribed:

EPSDT – Early and Periodic Screening, Diagnostic and Treatment Services are designed for Medicaid-eligible children under the age of twenty-one (21) that include periodic screenings to identify physical and mental conditions, vision, hearing and dental, as well as diagnostic and treatment services to correct conditions identified during screenings.

Individual Habilitation Plan (IHP) – That plan as set forth in section 403 of the Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978, effective March 3, 1979 (D.C. Law 2-137; D.C. Official Code § 7-1304.03).

Individual Support Plan – The successor to the IHP as defined in the 2001 Plan for Compliance and Conclusion of *Evans v. Williams*.

Physical Therapist – An individual who is licensed to practice physical therapy pursuant to section 501 of the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1205.01) or licensed as a physical therapist in the jurisdiction where services are provided.

Physical Therapy Services – The practice of physical therapy, as defined by section 102(12)(A) of the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.02(12)(A)).

Physical Therapy Aide – An individual who works only under the direct supervision of a physical therapist, and whose activities do not require advanced training in, or complex application of, therapeutic procedures or other standard procedures involved in the practice of physical therapy.

Physical Therapy Assistant – An individual who is licensed to practice as a physical therapy assistant pursuant to section 501 of the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1205.01) or licensed to practice as a physical therapy assistant in the jurisdiction where services are provided.

Physician – An individual who is licensed to practice medicine pursuant to section 501 of the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 D.C. Law 6-99; D.C. Official Code § 3-1205.01) or licensed to practice medicine in the jurisdiction where services are provided.

Person – An individual with intellectual and developmental disabilities who has been determined eligible to receive services under the Waiver.

Plan of Care – A written service plan that meets the requirements set forth in section 1904.4 of Title 29 DCMR, is signed by the person receiving services, and is used to pre-authorize Waiver services.

Private Practice – An individual whose practice is a partnership or an unincorporated solo practice. Private practice also includes an individual who is practicing physical therapy as an employee of an unincorporated practice, a professional corporation, or other incorporated therapy practice. For the purposes of this rule, an individual who is licensed to practice physical therapy and is employed by a social services agency providing physical therapy service under this rule shall be considered in private practice. Private practice does not include individuals working as employees of a hospital, nursing facility, clinic, home health agency, rehabilitation facility, or any other entity that has a Medicaid provider agreement which includes physical therapy in the provider's reimbursement rate.

Progress Note – A dated, written notation by a member of the physical therapy services team that summarizes facts about a person's care and response to treatment during a given period of time.

Provider – An individual or business entity that provides physical therapy services pursuant to this chapter.

Waiver – The Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities as approved by the Council of the District of Columbia (Council) and the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), as may be further amended and approved by the Council and CMS.

Comments on the proposed rules shall be submitted in writing to Robert T. Maruca, Senior Deputy Director, Medical Assistance Administration, Department of Health, 825 North Capitol Street, N.E., 5th Floor, Washington, D.C. 20002, within thirty (30) days from the date of publication of this notice in the *D.C. Register*. Copies of the proposed rules may be obtained from the same address.

DEPARTMENT OF HEALTH

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth in an Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption, on an emergency basis, of an amendment to section 935 of Chapter 9 of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR), entitled "Occupational Therapy Services." These rules establish standards governing reimbursement by the District of Columbia Medicaid Program for occupational therapy services provided by a licensed occupational therapist to participants with mental retardation and developmental disabilities in the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver), which was approved the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, with an effective date of November 20, 2007.

A notice of emergency and proposed rulemaking was published on December 7, 2007 (54 DCR 11747). No comments were received. The December 7th rulemaking changed the previously published rules at 53 DCR 102 (January 6, 2006), by adding more effective planning and follow-up reporting and setting the reimbursement rate at sixty-five dollars ($65) per hour. This rulemaking further changes the December 7th rulemaking by modifying the definition of private practice so that qualified social services agencies employing licensed occupational therapists can provide occupational therapy services.

Emergency action is necessary for the immediate preservation of the health, safety, and welfare of Waiver participants who are in need of occupational therapy services. These emergency rules are needed so that, on the expiration date of the previous notice of emergency and proposed rulemaking for occupational therapy services on March 18, 2008, there will be rules in place consistent with the provisions of the Waiver as modified to add more effective planning and follow-up reporting, to set the reimbursement rate at sixty-five dollars ($65) per hour, and to permit qualified social services agencies employing licensed occupational therapists to provide these Waiver services.

The emergency rulemaking was adopted on March 13, 2008, and shall become effective on March 19, 2008. The emergency rules shall remain in effect for 120 days or until July 11, 2008, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*, whichever comes first.

The Director also gives notice of the intent to take final rulemaking action to adopt these proposed rules not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

Section 935 (Occupational Therapy Services) of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

935 OCCUPATIONAL THERAPY SERVICES

935.1 Occupational therapy services shall be reimbursed by the Medicaid Program for each participant in the Home and Community-Based Services Waiver for Persons with Mental Retardation and Developmental Disabilities subject to the requirements set forth in this section.

935.2 To be eligible for reimbursement, occupational therapy services shall be:

(a) Ordered by a physician;

(b) Reasonable and necessary to the treatment of the person's illness, injury, or long term disability or to the restoration or maintenance of function affected by the injury, illness or long term disability; and

(c) Included in the person's individual habilitation plan (IHP) or individual support plan (ISP) and Plan of Care.

935.3 Each person providing occupational therapy services shall be an employee of a home health agency or an occupational therapist in private practice with a current District of Columbia Medicaid Provider Agreement that authorizes the provider to bill for occupational therapy services under the Waiver.

935.4 In addition to the other requirements of this section, the occupational therapist in private practice shall meet all of the following conditions:

(a) Maintain a private office, even if services are always furnished in the person's home;

(b) Meet all state and local licensure laws and rules;

(c) Maintain a minimum of one (1) million dollars in liability insurance;

(d) Ensure that occupational therapy services are provided consistent with the person's IHP or ISP and Plan of Care;

(e) If services are provided in a private practice office space, the space shall be owned, leased or rented by the private practice and be used exclusively for the purpose of operating the private practice; and

(f) An occupational therapy assistant, licensed in the District of Columbia (D.C. Laws 16-220 and 16-221) or in the state where services are provided, shall be personally supervised by the occupational therapist.

Occupational therapy assistants shall also be employed by the occupational therapist or the partnership group to which the occupational therapist belongs or the same private practice that employs the occupational therapist. Personal supervision requires the occupational therapist to be in the room during the performance of the service.

935.5 Each person providing occupational therapy services shall:

(a) Be a licensed occupational therapist or be an occupational therapy assistant working under the direct supervision of a licensed occupational therapist;

(b) Have a minimum of two (2) years of experience as an occupational therapist or occupational therapy assistant;

(c) Be acceptable to the person to whom services are provided;

(d) Demonstrate annually that he or she is free from communicable disease as confirmed by an annual PPD Skin Test or documentation from a physician;

(e) Have at least one (1) year of experience working with persons with mental retardation and developmental disabilities;

(f) Agree to carry out the responsibilities to provide services consistent with the person's IHP or ISP and Plan of Care;

(g) Complete pre-service and in-service training approved by DDS;

(h) Have the ability to communicate with the person to whom services are provided;

(i) Be able to read, write, and speak the English language; and

(j) Comply with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13, 2002 (D.C. Law 14-98; D.C. Official Code § 44-551 *et seq.*).

935.6 Each occupational therapist shall provide the Department on Disability Services (DDS) and the Medical Assistance Administration with a brochure listing their academic background, licensure information, experience and the nature of their practice to assist those who may receive services in making their provider selection.

935.7 An occupational therapist, without regard to their employer of record, shall be selected by the person receiving services or their guardian or legal representative to provide services to the person receiving services and shall be answerable to the person receiving services. Any organization substituting practitioners for more than a two week period or four visits due to emergency or availability events shall request a case conference with the DDS Case Manager so that the person receiving services can select a new practitioner.

935.8 The duties of each person providing occupational therapy services shall include, at a minimum, the following:

(a) Preparing a report that summarizes the physician's order, measures the person's strength, range of motion, balance and coordination, posture, muscle performance, respiration, and motor functions and developing and describing treatment plans that describe treatment strategies including direct therapy, training caregivers, monitoring requirements, monitoring instruments, monitoring instructions, and anticipated outcomes;

(b) Maintaining ongoing involvement and consultation with other service providers and caretakers;

(c) Ensuring that the person's needs are met in accordance with the physician's order;

(d) Providing consultation and instruction to the person, family, or other caregivers;

(e) Recording progress notes on each visit; and

(f) Conducting periodic examinations and modifying treatments for the person receiving services, when necessary.

935.9 The occupational therapist shall be responsible for providing written documentation in the form of reports, assessments for occupational therapy services, physician's orders, visit notes, progress notes, and other pertinent documentation of the person's progress or lack of progress, medical conditions, functional losses, and treatment goals that demonstrate that the services are and continue to be reasonable and necessary. The documentation shall include evidence that services did not exceed the authorized frequency and duration as authorized for occupational therapy services in the physician's order. The agency or occupational therapist in private practice shall maintain a copy of the documentation for at least six (6) years after the person's date of service.

935.10 The reimbursement rate for occupational therapy services shall be sixty-five dollars ($65.00) per hour for a full assessment of the individual, preparation of

summary documentation, and delivery of that documentation. The billable unit of service for occupational therapy services shall be fifteen (15) minutes. A provider shall provide at least eight (8) minutes of service in a span of fifteen (15) continuous minutes to bill a unit of service. The tasks shall include updating medical records and verification that the documentation was delivered to the primary care physician, DDS Case Manager and the place of residence of the person receiving services.

935.11 The reimbursement rate for ongoing occupational therapy services shall be sixty-five dollars ($65.00) per hour for the period specified in the occupational therapy report and approved by the physician. The billable unit of service for occupational therapy services shall be fifteen (15) minutes. A provider shall provide at least eight (8) minutes of service in a span of fifteen (15) continuous minutes to bill a unit of service.

935.12 Each provider shall offer the Hepatitis B vaccination to each person providing services pursuant to these rules and maintain a copy of the acceptance or declination of the vaccine.

935.99 DEFINITIONS

When used in this section, the following terms and phrases shall have the meanings ascribed:

Clinical Record – A comprehensive compilation of medical and other data that identifies the person and justifies and describes the diagnosis and treatment of the person.

Individual Habilitation Plan (IHP) – That plan as set forth in section 403 of the Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978, effective March 3, 1979 (D.C. Law 2-137; D.C. Official Code § 7-1304.03).

Individual Support Plan (ISP) – The successor to the individual habilitation plan (IHP) as defined in the 2001 Plan for Compliance and Conclusion of *Evans v. Williams*.

Occupational Therapist – A person who is licensed or authorized to practice occupational therapy pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201 *et seq.*) or licensed as an occupational therapist in the jurisdiction where services are provided.

Occupational Therapy Assistant – A person who is authorized to practice as an occupational therapy assistant under the direct supervision of a licensed occupational therapist pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25; 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201 *et seq.*)

or licensed or authorized to practice as an occupational therapy assistant in the jurisdiction where services are provided.

Physician – A person who is authorized to practice medicine pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 D.C. Law 6-99; D.C. Official Code § 3-1201 *et seq.*) or licensed as a physician in the jurisdiction where services are provided.

Person – An individual with intellectual and developmental disabilities who has been determined eligible to receive services under the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver).

Plan of Care – A written service plan that meets the requirements set forth in section 1904.4 of Title 29 DCMR, is signed by the person receiving services, and is used to prior authorize Waiver services.

Private Practice – An individual whose practice is an unincorporated solo practice or unincorporated partnership. Private practice also includes an individual who is practicing therapy as an employee of an unincorporated practice, a professional corporation, or other incorporated therapy practice. For the purposes of this rule, an individual who is licensed to practice occupational therapy and is employed by a social services agency providing occupational therapy service under this rule shall be considered in private practice. Private practice does not include individuals when they are working as employees of a hospital, nursing facility, clinic, home health agency, rehabilitation facility or any other entity that has a Medicaid provider agreement which includes physical therapy in the provider's reimbursement rate.

Progress Note – A dated, written notation by a member of the health care team that summarizes facts about a person's care and response to treatment during a given period of time.

Provider – Any non-profit, home health agency, social service agency or other business entity that provides services pursuant to these rules.

Waiver – Shall mean the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities as approved by the Council of the District of Columbia (Council) and the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), as may be further amended and approved by the Council and CMS.

Comments on the proposed rules shall be submitted in writing to Robert T. Maruca, Senior Deputy Director, Medical Assistance Administration, Department of Health, 825 North Capitol Street, N.E., 5th Floor, Washington, D.C. 20002, within thirty (30) days from the date of publication of this notice in the *D.C. Register*. Copies of the proposed rules may be obtained from the same address.

DEPARTMENT OF HEALTH

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth in An Act to enable the District of Columbia to receive Federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption, on an emergency basis, of an amendment to section 993 of Chapter 9 of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR), entitled "Independent Habilitation Services." These rules establish standards governing reimbursement by the District of Columbia Medicaid Program for independent habilitation services, which is renamed Supported Living Services, and is provided by qualified professionals to participants with mental retardation and developmental disabilities in the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver), which was approved the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, with an effective date of November 20, 2007.

A notice of emergency and proposed rulemaking was published on December 28, 2007 (54 DCR 12680). No comments were received. The December 28th rulemaking changed the name of the rules previously published at 54 DCR 6435 (June 29, 2007) from "Independent Habilitation Services" to "Supported Living Services", and provided a blend of the previously-available services under the former Waiver (*i.e.* Homemaker Services, Chore Services, Adult Companion Services, Personal Care Services, Attendant Care Services, and Independent Habilitation Services) that will be delivered under the Waiver based on a plan developed by the person and his/her support team. This service delivery approach will address the problems encountered when multiple provider agencies and support staff were needed to deliver supports in a person's home due to the different provider qualifications and restrictions for each service. The rule is intended to resolve the staffing issues which had made it difficult to effectively support individuals in smaller unlicensed settings. Supported living services is a twenty-four (24) hour service limited to residences owned, leased or otherwise operated by the provider with three (3) or fewer residents. The reimbursement rates have been modified based on a new rate setting methodology and the collapsing of services into daily rates based on acuity. An acuity system has been implemented to address the varying support needs of the persons being served. The acuity system is based on the intensity of staffing required for each unique residence. This service may also be delivered as an hourly drop in service for person's who do not require paid and/or unpaid twenty-four (24) hour residential support.

This rulemaking further changes the December 28th rulemaking to use a fifteen (15) minute billing unit, to adjust rates to prevent duplicate billings for services for individuals whose participation in day/vocational activities exceeds the five (5) hour per day five (5) day per week schedule used in the rate methodology for residential habilitation services, to require the provider to give ninety (90) days written notice to the government and thirty (30) days

written notice to the participants of the intent to terminate residential habilitation services, and to clarify the criteria for one-to-one services and the rate for one-to-one services when more than one person in the same residence is receiving one-to-one services.

Emergency action is necessary for the immediate preservation of the health, safety, and welfare of Waiver participants who are in need of supported living services. These emergency rules are needed so that, on the expiration date of the previous notice of emergency and proposed rulemaking for supported living services, there will be rules in place consistent with the provisions of the Waiver as modified to provide supported living services in smaller unlicensed residences based on daily rates that are in turn based on the acuity level of the persons being served.

The emergency rulemaking was adopted on March 20, 2008, and became effective on that date. The emergency rules will remain in effect for 120 days or until July 17, 2008, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*, whichever comes first.

The Director also gives notice of the intent to take final rulemaking action to adopt these proposed rules not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

Section 993 (Independent Habilitation Services) of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

993 SUPPORTED LIVING SERVICES

993.1 Supported living services shall be reimbursed by the District of Columbia Medicaid Program for each participant in the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver) subject to the requirements set forth in this section.

993.2 In order to qualify for reimbursement under this section, supported living services shall be delivered in a Supported Living Residence (SLR) that can serve one (1) to three (3) persons and the number of persons in the home shall not exceed the number of bedrooms in that home. The SLR must be owned, leased or otherwise operated by the Supported Living Provider. The SLR shall meet the certification standards developed by the Department on Disability Services (DDS) as set forth in the Human Care Agreement between DDS and the SLR or be licensed or similarly certified in other states.

993.3 Each home located out-of-state shall be licensed or certified in accordance with the host state's laws and regulations and consistent with the terms and conditions set forth in an agreement between the District of Columbia and the host state. Each out-of-state provider shall comply with the following additional requirements:

(a) Remain in good standing in the jurisdiction where the program is located;
(b) Submit a copy of the annual certification or survey performed by the host state and provider's corrective action, if applicable, to DDS; and
(c) Allow authorized agents of the District of Columbia government, federal government, and governmental officials of the host state full access to all sites and records for audits and other reviews.

993.4 Supported living services shall be available only to a person with a demonstrated need for training, assistance and supervision, and shall be authorized and provided in accordance with the person's current Individual Habilitation Plan (IHP) or Individual Support Plan (ISP) and Plan of Care.

993.5 Each provider of supported living services shall assist participants in the acquisition, retention, and improvement of skills related to activities of daily living, such as personal grooming, household chores, eating and food preparation, and other social and adaptive skills necessary to enable the person to reside in the community. To accomplish these goals, the provider shall:

(a) Use observation, conversation, and other interactions as necessary to develop a functional analysis of the person's capabilities within the person's first month of service;
(b) Prepare a support plan with measurable outcomes using the functional analysis, the IHP or ISP and Plan of Care, and other information available to develop and maintain as appropriate the skills necessary to enable the person to reside in the community while maintaining the person's health and safety; and
(c) Prepare a data-based quarterly report for distribution to the person, family, guardian, and DDS Case Manager on the activities and support provided to help the person to achieve his/her identified outcomes and his/her progress to date.

993.6 Each provider of supported living services shall ensure that participants receive hands-on support, habilitation, and other supports, when appropriate, which shall include, but not be limited to, the following areas:

(a) Eating and drinking;
(b) Toileting;
(c) Personal hygiene;
(d) Dressing;
(e) Grooming;
(f) Monitoring health and physical condition and assistance with medication or other medical needs;
(g) Communication;
(h) Interpersonal and social skills;
(i) Home management;

(j) Mobility;
(k) Time management;
(l) Financial management;
(m) Academic and pre-academic skills, other than those prescribed by the Individuals with Disabilities in Education Act;
(n) Motor and perceptual skills;
(o) Problem-solving and decision-making;
(p) Human sexuality;
(q) Aesthetic appreciation; and
(r) Opportunity for social, recreational, and religious activities utilizing community resources.

993.7 Each provider of supported living services shall ensure that each participant receives the professional/medical services required to meet his or her goals as identified in the person's IHP or ISP and Plan of Care, through the support of the SLR provider to coordinate and ensure receipt of the professional/medical services. Professional/medical services may include, but are not limited to, the following disciplines or services:

(a) Medicine;
(b) Dentistry;
(c) Education;
(d) Nutrition;
(e) Nursing;
(f) Occupational therapy;
(g) Physical therapy;
(h) Psychology;
(i) Social work;
(j) Speech, hearing and language therapy; and
(k) Recreation.

993.8 Each provider of supported living services shall provide or ensure the provision of transportation services to enable the persons to gain access to Waiver and other community services and activities. If transportation services are provided by the SLR, the provider shall meet the requirements governing transportation services set forth in section 1903 of Title 29 DCMR.

993.9 Each provider of supported living services shall be a social services agency as described in Chapter 9 of Title 29 of the District of Columbia Municipal Regulations (DCMR), Section 1903.1. In addition, the provider shall:

(a) Be a member of the person's interdisciplinary team;
(b) Have a current District of Columbia Medicaid Provider Agreement that authorizes the provider to bill for Supported Living Services under the Waiver;
(c) Maintain a copy of the most recent IHP or ISP and Plan of Care that has been approved by DDS for each person;

(d) Have a current Human Care Agreement with DDS for the provision of residential services;
(e) Ensure that all supported living services staff are qualified and properly supervised pursuant to all applicable rules;
(f) Ensure that all providers have a plan to provide staff interpreters for non-English speaking persons;
(g) Ensure that the service provided is consistent with the person's IHP or ISP and Plan of Care;
(h) Offer the Hepatitis B vaccination to each person providing services pursuant to these rules;
(i) Provide staff training in infection control procedures consistent with the standards established by the Federal Centers for Disease Control and Prevention;
(j) Ensure compliance with DDS policies governing reporting of unusual incidents, human rights, behavior management, and protection of person's funds;
(k) Ensure that each SLR, to the extent necessary, is accessible to public transportation and emergency vehicles;
(l) Ensure that each SLR, to the extent necessary, is handicapped accessible and barrier-free;
(m) Provide a written staffing schedule for each location where services are provided;
(n) Comply with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13, 2002 (D.C. Law 14-98; D.C. Official Code § 44-551 *et seq.*).
(o) Provide DDS and the Department of Health's Medical Assistance Administration with at least ninety (90) days advance written notice of intent to terminate supported living services; and
(p) Provide persons receiving supported living services with at least thirty (30) days advance written notice prior to the effective date of the termination of services in the form prescribed by DDS and be responsible for notifying DDS of those persons who are undergoing treatment of an acute condition.

993.10 Each person providing supported living services for a person shall meet all of the requirements in Chapter 19 to Title 29 DCMR, section 1911 in addition to the requirements set forth below:

(a) Complete competency based training in emergency procedures; and
(b) Be certified annually in cardiopulmonary resuscitation and First Aid.

993.11 Each provider shall cooperate with the DDS service coordination in providing access and information as requested for case management visits and reviews.

993.12 Each provider of supported living services shall review the person's IHP or ISP and Plan of Care goals, objectives, and activities at least quarterly and more often, as necessary. The provider shall propose modifications to the IHP or ISP and Plan of Care, as appropriate. The results of these reviews shall be submitted to the case manager within thirty (30) days of the end of each quarter. Each provider shall participate in IHP or ISP and Plan of Care development so that community integration goals are clearly defined. Each provider shall also assist in the coordination of all services that a person may receive.

993.13 Each provider of supported living services shall maintain progress notes on a weekly basis, or more frequently if indicated, on the IHP or ISP and Plan of Care, participant attendance rosters on a daily basis, and maintain current financial records of expenditures of public and private funds for each person. The progress notes shall include at a minimum documentation that demonstrates:

(a) Progress in meeting each goal in the ISP assigned to the supported living services provider;
(b) A list of all community activities the person participates in and the person's response to each activity;
(c) Any unusual health events, side effects to medication, change in health status, behavioral event, use of a restrictive procedure or unusual incident; and
(d) Each visitor the person receives, special events, and any situation or event requiring follow-up.

993.14 Each provider of supported living services shall maintain all records and reports for at least six (6) years after the person's date of discharge.

993.15 Supported living services shall not be reimbursed when provided by a member of the person's family.

993.16 Reimbursement for supported living services under the Waiver shall not include:

(a) Cost of room and board;
(b) Cost of facility maintenance, upkeep and improvement, modifications or adaptations to a home to meet the requirements of the applicable life safety code; or
(c) Activities for which payment is made by a source other than Medicaid.

993.17 The reimbursement rate for supported living services shall include:

(a) All direct support staff and supervision of support staff;

(b) All nursing provided in the residence for medication administration, physician ordered protocols and procedures, charting, other supports as per physician's orders, and maintenance of Health Management Care Plan;
(c) Programmatic supplies and indirect expenses; and,
(d) General and administrative fees for waiver services.

The billable unit of service for supported living services shall be fifteen (15) minutes. A provider shall provide at least eight (8) minutes of service in a span of fifteen (15) continuous minutes to be able to bill a unit of service.

993.18 The reimbursement rate for supported living services shall be as follows:

(a) The Basic Support Level 1 staff asleep overnight daily rate for a SLR with three (3) residents shall be one hundred and ninety-five dollars ($195.00) for a direct care staff support ratio of 1:3 during all hours when residents are in the home billable in quarter hour units of two dollars and three cents ($2.03) per unit;
(b) The Basic Support Level 2 staff awake overnight daily rate for a SLR with three (3) residents shall be two hundred forty dollars ($240.00) for a direct care staff support ratio of 1:3 for staff awake overnight and 1:3 during all awake hours when residents are in the home billable in quarter hour units of two dollars and fifty cents ($2.50) per unit;
(c) The Moderate Support Level 1 staff asleep overnight daily rate for a SLR with three (3) residents shall be two hundred eighty-six dollars ($286.00) for a direct care staff support ratio of 2:3 for eight (8) hours a day, 1:3 during the remaining awake hours, and 1:3 staff asleep overnight coverage when residents are in the home billable in quarter hour units of two dollars and ninety-eight cents ($2.98) per unit;
(d) The Moderate Support Level 2 staff awake overnight daily rate for a SLR with three (3) residents shall be three hundred thirty dollars ($330.00) for a direct care staff support ratio of 2:3 for eight (8) hours a day, 1:3 during remaining awake hours, and 1:3 staff awake coverage when residents are in the home billable in quarter hour units of three dollars and forty-four cents ($3.44) per unit;
(e) The Intensive Support Level 1 daily rate for a SLR with three (3) residents shall be three hundred fifty-nine dollars ($359.00) for a direct care staff support ratio of 1:3 for staff awake overnight and 2:3 during all awake hours when residents are in the home and adjusted for increased absenteeism billable in quarter hour units of three dollars and seventy-four cents ($3.74) per unit;
(f) The Intensive Support Level 2 daily rate for a SLR with three (3) residents shall be four hundred fifty dollars ($450.00) for a direct care staff support ratio of 2:3 for staff awake overnight and 2:3 during all awake hours when residents are in the home and adjusted for increased

absenteeism billable in quarter hour units of four dollars and sixty-nine cents ($4.69) per unit;

(g) The Basic Support Level 1 staff asleep overnight daily rate for a SLR with two (2) residents shall be two hundred sixty-two dollars ($262.00) for a direct care staff support ratio of 1:2 staff asleep overnight coverage and 1:2 staff awake coverage during all hours when residents are in the home billable in quarter hour units of two dollars and seventy-three cents ($2.73) per unit;

(h) The Basic Support Level 2 staff awake overnight daily rate for a SLR with two (2) residents shall be three hundred twenty-two dollars ($322.00) for a direct care staff support ratio of 1:2 for staff awake overnight and 1:2 during all awake hours when residents are in the home billable in quarter hour units of three dollars and thirty five cents ($3.35) per unit;

(i) The Moderate Support Level 1staff awake overnight daily rate for a SLR with two (2) residents shall be three hundred eighty-three dollars ($383.00) for a direct care staff support ratio of 2:2 for four (4) hours a day, 1:2 during remaining awake hours and 1:2 staff awake coverage when residents are in the home billable in quarter hour units of three dollars and ninety-nine cents ($3.99) per unit;

(j) The Moderate Support Level 2 daily rate in a SLR with two (2) residents shall be four hundred forty-four dollars ($444.00) for a direct care staff support ratio of 1:2 for staff awake overnight and 2:2 for eight (8) hours a day, 1:2 during remaining awake hours when residents are in the home and adjusted for increased absenteeism billable in quarter hour units of four dollars and sixty-three cents ($4.63) per unit;

(k) The Intensive Support Level 3 daily rate in a SLR with two (2) residents shall be four hundred eighty-two dollars ($482.00) for a direct care staff support ratio of 1:2 for staff awake overnight and 2:2 for all awake hours when residents are in the home and adjusted for increased absenteeism billable in quarter hour units of five dollars and two cents ($5.02) per unit;

(l) The hourly rate for periodic supported living services shall be twenty-two dollars ($22.00) per hour billable in quarter hour units of five dollars and fifty cents ($5.50) per unit; and

(m) There shall be a specialized service rate determined through a negotiated request for proposals process when determined necessary by DDS to serve individuals with extraordinary medical and/or behavioral health needs.

993.19 Individualized twenty-four (24) hour one-to-one supervision shall only be permitted with prior annual approval of the DDS Human Rights Committee or a medical treatment plan signed by the person's physician. To be eligible for reimbursement for one-to-one supported living services, the person shall be required to have a behavior support plan and meet at least one of the

characteristics set out in section 979.12 for paraprofessional one-to-one services or at least one of the characteristics set out in section 979.13 for professional one-to-one services. For purpose of this section 993.19, in addition to the requirements for paraprofessional one-to-one services and professional one-to-one services as set out in section 979.99, supported living one-to-one services means services provided to one person exclusively by a supported living services provider who has been trained in all general requirements and possesses all training required to implement the person's specific behavioral and/or clinical protocols and support plans for a pre-authorized length of time. One-to-one supported living services shall be reimbursed at the daily rate of four hundred and ninety-five dollars ($495.00) for one-to-one services with awake overnight staff, billable in quarter hour units of five dollars and sixteen cents ($5.16) per unit. One-to-one supported living services with asleep overnight staff or for any additional people in the same house with another person receiving one-to-one services shall be reimbursed at the daily rate of four hundred three dollars ($403.00), billable in quarter hour units of four dollars and twenty cents ($4.20) per unit. The rate adjustment for multiple people in the same house receiving one-to-one services avoids duplication of administrative and management fees.

993.20 Acuity shall be determined by a review of each person's IHP or ISP or Plan of Care. Participants shall be designated with a support level that is consistent with their current staffing level if other acuity indicators are not yet in place. Any request(s) to increase or decrease staffing ratios shall be reviewed and adjudicated by a committee appointed by the Director of DDS that shall review current staffing levels, available health and behavioral records, and any available standardized acuity instrument results to determine if a person has a health or behavioral acuity that requires modified supports.

993.21 Long-term twenty-four (24) hour paid support single-person placements in a SLR are only permitted for a person having a history of challenging behaviors that may put others at risk and requires intensive supports as determined by a psychological assessment or pursuant to a court order. The psychological assessment shall be updated on an annual basis to determine the continued necessity for this single, twenty-four (24) hour placement.

993.22 Each provider of supported living services shall coordinate the delivery of necessary behavioral support services, and skilled nursing services from approved Waiver providers of those services based on the requirements of the IHP or ISP and Plan of Care.

993.23 Supported living services shall not be billed concurrently with the following Waiver services:

(a) Residential Habilitation;
(b) Respite;

(c) Host Home;
(d) Live-in Caregiver; and
(e) In-Home Supports.

993.24 Supported living services shall not be billed when the person is hospitalized, on vacation, or for any other period in which the person is not residing at the SLR. The reimbursement rates assume a ninety-three (93) percent annual occupancy, and unanticipated absence from day/vocational services or employment due to illness, and planned absence for holidays. Daily activities such as day treatment, day habilitation services, prevocational services, supported employment services, or employment are typically scheduled for five (5) hours per day five (5) days per week, and scheduling day activities in excess of five (5) hours per day five (5) days per week shall result in an hour-for-hour decrease in the supported living services reimbursement. Reimbursement shall be calculated based on the time the person is scheduled to be in their place of residence, except the provider may include the time that the individual is being transported by the provider to day programs, employment, professional appointments, community outings and events.

993.25 Direct care staff shall be dressed, alert and maintain support logs during the entire shift of awake hours. The provider shall maintain a log of scheduled activities that specifies when the person is scheduled to be in their home on a daily basis.

993.99 DEFINITIONS

When used in this section, the following terms and phrases shall have the meanings ascribed:

Awake – For purposes of staffing and determining the reimbursement rates for supported living services, awake hours of the day with absence from day program, weekend, or holiday shall be approximately 6:00 a.m. to 10:00 p.m., and for purposes of awake hours for all other days shall be approximately 6:00 am to 10:00 a.m. and 2:00 p.m. to 10:00 p.m.

Community Integration – Participation in events outside of the person's place of residence that may include shopping, dining, attending movies, plays, and other social events. The plan from section 993.12 should identify community and social events appropriate for the person.

Direct Care Staff – Individuals employed to work in a SLR who render the day-to-day, personal assistance that person requires in order to meet the goals of his or her IHP or ISP and Plan of Care.

Family – Any person who is related to the person receiving services by blood, marriage or adoption.

Individual Habilitation Plan (IHP) – That plan as set forth in section 403 of the Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978, effective March 3, 1979 (D.C. Law 2-137; D.C. Official Code § 7-1304.03).

Individual Support Plan (ISP) – The successor to the individual habilitation plan (IHP) as defined in the 2001 Plan for Compliance and Conclusion of *Evans v. Williams*.

Interdisciplinary Team – A group of persons with special training and experience in the diagnosis and habilitation of mentally retarded persons who have the responsibility of performing a comprehensive person evaluation while participating in the development, implementation, and monitoring of the person's IHP or ISP and Plan of Care.

Overnight – For purposes of staffing and the reimbursement rates for supported living services, the overnight period shall be approximately from 10:00 p.m. to 6:00 a.m.

Person or Participant – An individual with intellectual and developmental disabilities who has been determined eligible to receive services under the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver).

Plan of Care – A written service plan that meets the requirements set forth in section 1904.4 of Title 29 DCMR, is signed by the person receiving services, and is used to prior authorize Waiver services.

Progress Notes – Notes that observe (1) progress in meeting each goal in the IHP or ISP and Plan of Care, which is the responsibility of the residence; (2) the list of community activities for the week and the participant's response to each activity; (3) any unusual health events; (4) any visitors the participant received; and (5) anything requiring follow-up or action.

Provider – Any non-profit, home health agency, social service agency or other business entity that provides services pursuant to these rules.

Supported Living Residence (SLR) - A community residence or home, other than an intermediate care facility for persons with mental retardation, which provides a homelike environment for not more than three (3) related or unrelated persons who require specialized living arrangements and maintains necessary staff, programs, support services, and equipment for their care and habilitation.

Waiver – Shall mean the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities as approved by the Council of the District of Columbia (Council) and the U.S. Department of Health and Human

Services, Centers for Medicare and Medicaid Services (CMS), as may be further amended and approved by the Council and CMS.

Comments on the proposed rules shall be submitted in writing to Robert T. Maruca, Senior Deputy Director, Medical Assistance Administration, Department of Health, 825 North Capitol Street, N.E., 5th Floor, Washington, DC 20002, within thirty (30) days from the date of publication of this notice in the *D.C. Register*. Copies of the proposed rules may be obtained from the same address.

DEPARTMENT OF HEALTH

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth in An Act to enable the District of Columbia to receive Federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat.744; D.C. Official Code § 1-307.02), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption, on an emergency basis, of a new section 1915 of Chapter 19 of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR), entitled "Host Home Services." These rules establish standards governing reimbursement by the District of Columbia Medicaid program for host home services provided by community homeowners and qualified professionals to participants with mental retardation and developmental disabilities in the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver), which was approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, with an effective date of November 20, 2007.

A notice of emergency and proposed rulemaking was published on December 14, 2007 (54 DCR 12088). No comments were received. This rulemaking amends the December 14th rules by changing the rates, the methodology, and the scope of services available to support homeowners in the community who support persons in the Waiver to live in their home. The homeowner will utilize a portion of the participant's benefits and income for room and board as determined by the Department on Disability Services (DDS). Direct support services and supervision are funded through the Waiver under foster care payment rules. Host Home Services are to be operated by Residential Habilitation Services and Supported Living Services providers who will recruit, train, supervise, and support the homeowner. The service will have a daily rate that includes the direct service and a portion of the rate to be applied to the contract provider to coordinate services and provide respite and other supports as necessary.

Emergency action is necessary for the immediate preservation of the health, safety, and welfare of Waiver participants who are in need of host home services. These emergency rules are needed so that, on the expiration date of the previous notice of emergency and proposed rulemaking for host home services on March 18, 2008, there will be rules in place consistent with the provisions of the Waiver as modified to permit homeowners in the community to support persons in the Waiver to live in their home.

The emergency rulemaking was adopted on March 20, 2008, and became effective on that date. The emergency rules will remain in effect for 120 days or until July 17, 2008, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*, whichever comes first.

The Director also gives notice of the intent to take final rulemaking action to adopt these proposed rules not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

New section 1915 (Host Home Services) of Chapter 19 of Title 29 DCMR is added to read as follows:

1915 HOST HOME SERVICES

1915.1 Host home services shall be reimbursed by the District of Columbia Medicaid Program for each participant in the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver) subject to the requirements set forth in this section.

1915.2 To be eligible for reimbursement, host home services shall be provided in a Host Home that meets the Department on Disability Services (DDS) Certification Standards as set forth in the Human Care Agreement between the Host Home, the Contract Provider, and DDS.

1915.3 Each host home located out-of-state shall be licensed or certified in accordance with the host state's laws and regulations and consistent with the terms and conditions set forth in an agreement between the District of Columbia and the host state. Each out-of-state provider shall comply with the following additional requirements:

(a) Remain in good standing in the jurisdiction where the program is located;
(b) Submit a copy of the annual certification or survey performed by the host state and provider's corrective action to DDS; and
(c) Allow authorized agents of the District of Columbia government, federal government, and governmental officials of the host state full access to all sites and records for audits and other reviews.

1915.4 Host home services shall only be available to a person with a demonstrated need for training, assistance, and supervision, and shall be authorized and provided in accordance with the person's current Individual Habilitation Plan (IHP) or Individual Support Plan (ISP) and Plan of Care.

1915.5 Host home services refer to a residential arrangement in which a homeowner provides room, board, personal supports and assistance to a person in a Host Home. The services provided by a Host Home shall include, but are not limited to:

(a) Room and board (not included in the Waiver reimbursement rate);
(b) Light homemaker tasks, such as assistance with meal preparation;

(c) Light chore tasks, such as assistance with laundry, shopping, and general housekeeping;
(d) General supervision of the person as described in the IHP or ISP and Plan of Care;
(e) Maintenance of medical records;
(f) Maintenance of financial records;
(g) Maintenance of the IHP or ISP and Plan of Care;
(h) Assistance with attending health care appointments, including coordinating, but not providing, transportation to and from the appointments;
(i) Assistance with planning and attending community events; and
(j) Providing habilitative support in activities of daily living and/or therapeutic goals and objectives as described in the IHP or ISP and Plan of Care.

1915.6 Host homes services shall be administered by Supported Living Service or Residential Habilitation Service providers, which in this section shall be referred to as the Contract Provider. Each Contract Provider of host home services shall be a social services agency as described in Chapter 19 of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR), Section 1903.1. In addition, the Contract Provider agrees to:

(a) Be a member of the person's interdisciplinary team;
(b) Have a current District of Columbia Medicaid Provider Agreement that authorizes the provider to bill for Residential Habilitation Services or Supported Living Services under the Waiver;
(c) Maintain a copy of the most recent IHP or ISP and Plan of Care that has been approved by DDS for each person;
(d) Ensure that all persons associated with host home services are qualified and properly supervised to include having a plan to provide staff interpreters for non-English speaking individuals;
(e) Ensure that the service provided is consistent with the person's IHP or ISP and Plan of Care;
(f) Offer the Hepatitis B vaccination to each person providing services pursuant to these rules;
(g) Provide staff training in infection control procedures consistent with the standards established by the Federal Centers for Disease Control and Prevention;
(h) Ensure compliance with DDS policies governing reporting of unusual incidents, human rights, behavior management, and protection of person's funds; and
(i) Comply with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of

1915.7 Each person providing host home services shall meet all of the requirements in Chapter 19 to Title 29 of the District of Columbia Municipal Regulations (DCMR), section 1911, "Requirements for employees providing direct services."

1915.8 Each person providing host home services agrees to cooperate and attend mandatory trainings sessions provided by DDS and the Contract Provider and to allow DDS case managers and other DDS employees free and unfettered access to the Host Home.

1915.9 The role of the Contract Provider in Host Home placement shall be to:

(a) Receive and review packets submitted by the DDS requesting development of a Host Home for a particular applicant;
(b) Respond to inquiries for Host Home development in a timely manner;
(c) Recruit appropriate Host Home settings for persons;
(d) Identify and develop on-going working relationships with needed local professional resources (*e.g.*, dentist, physician, psychiatrist, psychologist, occupational therapist, physical therapist, etc.);
(e) Provide for a minimum of one (1) visit by the participant to the prospective home, one of which may be an overnight stay if more visits are possible;
(f) Coordinate transportation in cooperation with the DDS case manager for visits to the prospective Host Home;
(g) Participate in a person centered planning process to develop the participant's IHP or ISP and Plan of Care;
(h) Arrange for essential supports to be in place prior to a participant's move into a Host Home setting, including provision of training to support persons and provision of necessary supplies and equipment;
(i) Arrange for non-essential but recommended and necessary supports to be put into place subsequent to a participant's move into a Host Home setting; and
(j) Provide information as needed to the participant and responsible party, DDS and the Host Home.

1915.10 The Contract Provider shall be responsible for coordinating compliance with DDS policies and procedures governing reporting of unusual incidents, human rights, behavior management, and protection of person's funds using, but not limited to, by the following means:

(a) Contract Providers shall provide Host Homes with appropriate training on DDS policies;

(b) Contract Providers shall provide Host Homes with appropriate training on incident reporting procedures; and
(c) Contract Providers shall coordinate each incident investigation at Host Homes.

1915.11 The Contract Provider shall coordinate the delivery of professional services to persons in Host Homes that may include, but are not limited to, the following disciplines or services:

(a) Health Care;
(b) Dentistry;
(c) Education;
(d) Nutrition;
(e) Nursing;
(f) Occupational therapy;
(g) Physical therapy;
(h) Behavioral Support;
(i) Community Supports;
(j) Social work;
(k) Speech, hearing and language therapy; and
(l) Recreation.

1915.12 The Contract Provider shall coordinate the use of transportation for persons in Host Homes to day programs, places of employment, and/or community outings as needed.

1915.13 The Contract Provider shall coordinate general support monitoring at least twice per month to update activity schedules, reviewing medical and other appointments, making progress notes, and reviewing conditions in the Host Home and the status of the person.

1915.14 The Contract Provider shall coordinate health care monitoring for persons in Host Homes including, at a minimum, monitoring by a registered nurse at least every sixty (60) days for persons with no medications, and monthly for charting, progress notes, and a general review of persons receiving medications.

1915.15 The Contract Provider shall provide respite to the caregiver and emergency support up to a total of fourteen (14) days per year. If respite and emergency support services are provided in the Host Home, then host home services payments shall continue. If respite and emergency support services are provided in another location, then the host home services percentage of the reimbursement rate shall be paid to the Contract Provider.

1915.16 Each Host Home and Contract Provider shall assist residents in the acquisition, retention, and improvement of skills related to activities of daily

living, such as personal grooming, household chores, eating and food preparation, and other social adaptive skills necessary to enable the person to reside in the community. To accomplish these goals, the Host Home and Contract Provider shall:

(a) Within the first month of residence, use observation, conversation, and other interactions as necessary to develop a functional analysis of the person's capabilities;
(b) Develop a plan with measurable outcomes using the functional analysis, the IHP or ISP and Plan of Care, and other information available to identify to the extent possible the skills necessary to enable the person to reside in the community while maintaining the person's health and safety; and
(c) On a quarterly basis, report to the person, family, guardian, DDS Case Manager on the programming and support provided to help the person to achieve the identified outcomes.

1915.17 Each Contract Provider of host home services shall ensure the coordination of transportation services to enable the person to gain access to Waiver and other community services and activities.

1915.18 Each Contract Provider of host home services shall maintain all records and reports for at least six (6) years after the person's date of discharge.

1915.19 The following individuals shall not be permitted to provide host home services:

(a) Legal guardian;
(b) Parent of a minor child; or
(c) Spouse.

1915.20 The reimbursement rate for host home services is a daily inclusive rate based on acuity of the participant. The acuity level will be determined by DDS based on the results of the Support Intensity Scale or as documented in the person's ISP or IHP. The basic support rate shall be one hundred thirty-six dollars ($136.00) per day; the moderate support rate shall be one hundred fifty-three dollars ($153.00) per day; and the intensive support rate shall be one hundred ninety-six dollars ($196.00) per day. A specialized rate also shall be available by negotiation for individuals with extraordinary medical support needs as set by DDS with Department of Health, Medical Assistance Administration approval. The host home services reimbursement rate shall include:

(a) All training for Host Home workers;
(b) Programmatic supplies;
(c) Oral/topical medication management;
(d) General and administrative fees for waiver services;
(e) Relief of the caregiver and emergency support;

(f) All direct support costs based on the needs of the individual; and
(g) Additional in-home supports from five (5) to twenty (20) hours per week.

1915.21 Fifty (50) percent of the daily reimbursement rate shall be paid to the host home by the Contract Provider for support services. The remaining fifty (50) percent of the daily reimbursement rate shall be retained by the Contract Provider for training, additional in-home support services based on the needs of the individual, medication management, general and administrative fees for waiver services, general supervision, and relief and emergency coverage.

1915.22 Host home services shall not be payable or be billed for the same day that the following other Waiver services are provided to the person:

(a) Supported Living;
(b) Residential Habilitation;
(c) Personal Care;
(d) Live-In Caregiver;
(e) Respite; or
(f) In-Home Supports.

1915.23 Host home services shall not be payable or be billed when the person is hospitalized, on vacation, or for any other period in which the person is not residing at the Host Home.

1915.99 DEFINITIONS

When used in this section, the following terms and phrases shall have the meanings ascribed:

Contract Provider – A Supported Living Service provider or Residential Habilitation Service provider which, in accordance with this section, is administering Host Home Services at a Host Home on behalf of a Homeowner.

Direct Care Staff – Individuals employed to work in the Host Home who render the day-to-day personal assistance that person's require in order to meet the goals of their IHP or ISP and Plan of Care.

Individual Habilitation Plan (IHP) – That plan as set forth in section 403 of the Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978, effective March 3, 1979 (D.C. Law 2-137; D.C. Official Code § 7-1304.03).

Individual Support Plan (ISP) – The successor to the individual habilitation plan (IHP) as defined in the 2001 Plan for Compliance and Conclusion of *Evans v. Williams*.

Interdisciplinary Team – A group of persons with special training and experience in the diagnosis and habilitation of mentally retarded persons who have the responsibility of performing a comprehensive person evaluation while participating in the development, implementation, and monitoring of the person's IHP or ISP and Plan of Care.

Homeowner – A person(s) who is(are) the primary owner or leasor of a residential property. Evidence satisfactory to the Department on Disability Services of a title or a lease must be provided annually or any time a move is proposed.

Host Home – The residence owned or leased by the Home Owner where the person will reside for purposes of host home services under the Waiver.

Licensed Practical Nurse – A person who is licensed to practice practical nursing pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986, (D.C. Law 6-99; D.C. Official Code § 3-1201 *et seq.*) or licensed as a practical nurse in the jurisdiction where services are provided.

Person – An individual with intellectual and developmental disabilities who has been determined eligible to receive services under the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver).

Plan of Care – A written service plan that meets the requirements set forth in section 1904.4 of Title 29 DCMR, is signed by the person receiving services, and is used to prior authorize Waiver services.

Registered Nurse – A person who is licensed to practice registered nursing pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986, (D.C. Law 6-99; D.C. Official Code § 3-1201 *et seq.*) or licensed as a registered nurse in the jurisdiction where services are provided.

Waiver – Shall mean the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities as approved by the Council of the District of Columbia (Council) and the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), as may be further amended and approved by the Council and CMS.

Comments on the proposed rules shall be submitted in writing to Robert T. Maruca, Senior Deputy Director, Medical Assistance Administration, Department of Health, 825 North Capitol Street, N.E., 5th Floor, Washington, DC 20002, within thirty (30) days from the date of publication of this notice in the *D.C. Register*. Copies of the proposed rules may be obtained from the same address.